NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF MEDICAID MANAGEMENT

Enrollee/Patient Request for Specific Medicaid Protected Health Information

Federal regulations permit you to request a specific designated record set. We will try to meet your request. If you wish to request this information, please complete the following:

Name:_____

Client Identification Number (CIN): _____

Date of Birth:_____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Dates of records requested: From :_____ To: _____

Reason:

_____

_____

_____ _____

Enrollee/Patient Signature Date

Forward form to: Claim Detail Unit
Address: NYS Department of Health
Office of Medicaid Management
99 Washington Avenue
7th Floor Suite 720
Albany, NY 12210

Phone Number: (518) 473-4848